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Parental Irrational Beliefs and Their Impact on the Rehabilitation of Children with Intellectual Disabilities

Munaza Rafique[1], Dr. Muhammad Anwer[2], Khalil Ahmad[3], Asma Fiaz[4] & Javeria Khan[5]

[1]*PhD Scholar (Educational Leadership and Policy Studies), University of Education, Lahore, Email: munazarafique@gmail.com*
[2]*Associate Professor, Division of Education, University of Education, Lahore, Email: dranwer@ue.edu.pk*
[3]*MPhil Scholar (Special Education), Department of Special Education, University of Education, Lahore, Email: khalil.ahmad@ue.edu.pk*
[4]*MPhil (Educational Leadership and Policy Studies), University of Education, Lahore, Email: asmafiaz28@gmail.com*
[5]*MPhil Scholar (Educational Leadership and Policy Studies) University of Education, Lahore, Email: info.javeriakhan@gmail.com*

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Corresponding Author:
Dr. Muhammad Anwer
Email:
dranwer@ue.edu.pk

ABSTRACT

This study explored the irrational beliefs of parents of children with intellectual disabilities in Pakistan, drawing on Albert Ellis's Rational Emotive Behavior Therapy (REBT) theory—the research aimed to identify and analyze these beliefs and their potential negative influence on the rehabilitation process. Using a purposive sampling technique, the study surveyed 150 parents from 11 government special schools in Lahore, with 50 parents of children with mild mental retardation and 100 with moderate mental retardation. A 20-item self-developed questionnaire was the primary tool for data collection. The findings revealed that most parents exhibited an extreme level of irrational beliefs, particularly demanding attitudes expressed with terms like "should," "must," and "ought". While an independent samples t-test showed a non-significant difference on the majority of variables between the two groups, significant differences were found on a few specific variables. The research concludes that these irrational beliefs can hinder the effectiveness of special education efforts. It emphasizes the need for a collaborative approach between parents and special education professionals to improve outcomes for children. This study provides a foundational understanding for developing targeted parental counseling and therapeutic interventions to confront and transform these irrational beliefs into more rational, supportive ones.

Introduction

The rehabilitation of children with intellectual disabilities (ID) is critically influenced by parental beliefs. In particular, irrational beliefs—rigid, absolutist thought patterns rooted in emotional

disturbances—can significantly affect parenting behaviors, engagement with rehabilitation services, and ultimately, the child's developmental progress. Drawing from Rational Emotive Behavior Therapy (REBT), irrational beliefs are understood as demandingness (e.g., "I must succeed"), awfulizing ("It's unbearable if expectations aren't met"), low frustration tolerance, and self- or other-deprecation (Ellis, 1957). These cognitive distortions create emotional and behavioral obstacles to adaptive coping (Rational Emotive Behavior Therapy, 2025).

In families of children with moderate to profound intellectual disabilities, parents are fundamental to caregiving and rehabilitation due to limited external services, especially in non-Western contexts (Barratt et al., 2025). While Western systems may offer some support, children with more severe disabilities frequently rely wholly on parental care, which can profoundly affect parents' quality of life, mental health, and capacity to engage in rehabilitation strategies. Parental stress, diminished quality of life, and psychological strain can undermine sustained involvement in rehabilitation processes and impede optimal outcomes for their children.

Such irrational beliefs are also attributed to depressive and anxious disorders. Irrational beliefs may serve as the predictors of depressive disturbance (Ede et al., 2023). Within the context of parenting children with ID, negative beliefs may lead to maladaptive expectations (e.g. My child has to improve fast), increase emotional distress when there is slow progress, and decrease resilience. This is buttressed by findings that report that when depressed parents receive therapeutic interventions specifically the REBT-based interventions, their irrational thinking has the potential to be reconfigured and adhere to more rational and adaptive thought patterns (Ugwuanyi et al., 2022).

Beliefs regarding the disability of their child also play a very significant role in parental involvement in the rehabilitation process. A study comparing beliefs in cross disabilities shows that such beliefs have far-reaching implications on intervention options made by the parents and parent satisfaction with interventions (Mushtaq et al., 2024). Parents whose beliefs are irrational or culturally ingrained may obstruct or block therapeutic prescriptions or not be forthcoming in any aspects of the rehabilitation program. On the other hand, the implementation of evidence-based interventions by patients with more adaptive beliefs will potentially hold better and engage with interventions proactively.

However, some parents say that they grow stronger, more self-confident, and able to accept life and appreciate it (Horsley & Oliver, 2015). This association of experience, where negative and positive co-existence, is an indication that, although irrational beliefs lead to dysfunction, adaptive framing and support can be used to help parents to harness growth-oriented mindsets. However, positive reframing may need to be facilitated actively and re-conceptualized cognitively.

Cultural and social context significantly shapes both parental beliefs and engagement in rehabilitation. In the United Arab Emirates, for instance, mothers report high levels of fathers' support in training and caregiving, yet also perceive ambivalence in fathers' attitudes toward raising children with ID (Mohamed et al., 2024). This highlights how gender dynamics and cultural norms intersect with belief systems and caregiving practices, affecting rehabilitation participation and family dynamics. In many societies, mothers bear the caregiving burden, while fathers' participation may be mediated by their beliefs about disability and societal expectations.

While numerous studies address parental stress, quality of life, and even positive change, few specifically examine how *irrational beliefs*—as defined in REBT—shape parental engagement in

rehabilitation. Most research centers on broad constructions such as stress or depression, with limited focus on cognitive distortions as key mediators of parental behavior. Furthermore, the impact of these beliefs on rehabilitation, adherence, and outcomes remains underexplored.

By focusing explicitly on irrational beliefs, rather than broader psychosocial constructs, this research sharpens our understanding of cognitive factors that disrupt or facilitate sustainable rehabilitation involvement. Moreover, it aligns with REBT theoretical foundations, leveraging a well-supported therapeutic framework to conceptualize parental cognition and behavior.

Objectives of the Study

- To investigate the irrational beliefs of parents of children with intellectual disabilities.
- To compare the irrational beliefs of parents of children with mild and moderate intellectual disabilities.
- To investigate the impact of parental irrational beliefs on children's adaptive and rehabilitative outcomes.

Literature Review

Rational Emotive Behavior Therapy (REBT) by Albert Ellis, formulates the faulty thinking as the key causes of maladaptive behavior and emotions (Ellis, 1957). The four fundamental types that based on REBT are demands, low frustration tolerance, and depreciation. In a more parenting-specific setting, it has been shown that irrational beliefs that parents hold are frequently reflective of the four structures mentioned, namely, perfectionism or unrealistic expectations on the parenting roles, blown catastrophizing of parenting events, intolerance of adversity and personal worth attribution to failure or success of parenting (Çekiç et al., 2025). These cognitions are dysfunctional and make parents more prone to elevated stress, anxiety, depression, negative emotionality, and poor parent-child relations (Ogurlu & Kahraman, 2018).

Empirical literature constantly shows associations between parents' irrational beliefs and their own psychological distress. Meta-analytic evidence across 15 studies indicates significant effect sizes, particularly for general irrational beliefs and smaller though meaningful associations with children's negative mental health. Notably, cultural variation emerges: effect sizes were highest in studies from the USA, and lowest in Turkey (Çekiç et al., 2025). Parent irrational beliefs are further linked to elevated stress, maladaptive emotion regulation, anxiety, depression, anger, social withdrawal, and relational difficulties within the family (Çekiç et al., 2025).

A study exploring the interplay of irrational beliefs, emotion regulation, and parenting stress (N = 814) found that emotion regulation partially mediates this relationship and interestingly, this mediated pathway held for fathers but not mothers, pointing to gender-specific nuances in cognitive–emotional processes among parents (Uzun et al., 2025).

Parents' beliefs about the causes and nature of intellectual disability (ID) are deeply embedded in cultural, religious, and societal contexts. Qualitative inquiries in African settings have highlighted widespread beliefs attributing ID to witchcraft, punishment, curses, or parental moral failings, often compounded by stigma and secrecy—leading many families to conceal the child and lack access to educational or rehabilitation services (Lefakane, 2023). These studies, analyzed through Bronfenbrenner's ecological framework, reveal that micro- (family), meso- (community), and

macro-level (cultural, resource-related) dynamics co-shape parental experiences and caregiving practices (Mkabile et al., 2021).

A scoping review on parental expectations for children with developmental disabilities shows that cultural norms and systemic resources influence how parents perceive their child's potential. In some societies like Ghana and Zambia, parental expectations aligned more closely with teachers and clinicians; in other contexts, disparities emerged due to patriarchal norms or differences in access to services (Washington-Nortey et al., 2025). Financial and educational capital also mediates parents' ability to pursue interventions or relocate to access services, especially in resource-constrained settings.

In Pakistan, qualitative research on parents of children with intellectual disability revealed that beliefs deeply affect intervention strategies and satisfaction. Some parents view disability as either a divine reward or a form of punishment, with attendant fears about the child's future—shaping their choice of therapy, engagement, and satisfaction with services (Mushtaq et al., 2024). This aligns with global findings that parental belief systems influence the selection, immediacy, and persistence of interventions.

Moreover, systematic reviews of psychological interventions tailored to parents of children with ID show that interventions targeting both parental well-being and child interaction yield lasting improvements in parental mental health and child outcomes (Ranta et al., 2025). Incorporating REBT-based cognitive restructuring holds particular promise for re-aligning irrational beliefs, mitigating emotional distress, and strengthening rehabilitation outcomes (Ugwu, 2018).

Quantitative and qualitative studies have documented a dual reality: the caregiving journey often induces stress, poor mental health, and strained family relationships, yet can also yield positive meaning and resilience. In Karachi, mothers reported that caring for a child with intellectual disability had unexpectedly positive contributions to family life and acceptance of their situation (Lakhani et al., 2013). Cross-cultural data involving Irish, Taiwanese, and Jordanian mothers found elevated stress and poorer family functioning, which were unrelieved by coping strategies or support access—even though these mothers demonstrated strength and perseverance.

Research Methodology

This study employed a descriptive research design, suitable for investigating parental irrational beliefs and their impact on the rehabilitation of children with intellectual disabilities. Descriptive research allows for the systematic collection of data to identify existing attitudes, beliefs, and behaviors without manipulating variables. A purposive sampling method was used, and this allowed the parents of children with mild and moderate intellectual disabilities to be selected in the proportion of 50:100 parent samples respectively. Purposive sampling was confirmed to be the most suitable method of identifying participants who actually fulfilled the study eligibility criteria selecting the primary caregivers of children with intellectual disabilities (Etikan et al., 2016).

The research instrument was a self-designed questionnaire based on the rational emotive behavior therapy (REBT) and was constructed on the basis of previous scales that had been created to measure an irrational beliefs such as the general attitude and belief scale (GABS) (Lindner et al., 1999). The questionnaire included 20 closed-ended questions about irrational beliefs expressed on a five-point Likert scale of strongly agree to strongly disagree. The questionnaire also included three open-ended questions to provide details regarding the reasons that led to disability, the kind

of interventions employed, as well as the view about who should take responsibility to ensure rehabilitation. In order to maintain content validity, reviewers in special education and psychology were consulted, and a pilot study of 60 parents was done to determine reliability. The Cronbach's alpha coefficient obtained indicated acceptable internal consistency ($\alpha > 0.70$), consistent with thresholds suggested by Tavakol and Dennick (2011)

Data collection was carried out by personally administering the questionnaires to parents. This direct engagement helped reduce non-response bias and clarified ambiguities in real time. Ethical considerations were strictly followed: informed consent was obtained, anonymity and confidentiality were guaranteed, and participation remained voluntary. For data analysis, both descriptive and inferential statistics were applied. Descriptive statistics such as means, standard deviations, and frequency distributions were used to summarize parental irrational beliefs. Inferential analysis was conducted through independent samples *t*-tests to compare belief patterns between parents of children with mild and moderate intellectual disabilities. This test was deemed appropriate for identifying mean differences between two independent groups (Field, 2018). Responses from the open-ended questions were analyzed qualitatively using thematic content analysis to capture recurring themes and cultural patterns in parental thinking. The mixed-method approach thus provided both breadth and depth in understanding the phenomenon, ensuring triangulation of findings (Creswell & Clark, 2017).

Results

Table 1: Descriptive Statistics of Parents' Irrational Beliefs (N = 150)

Variable Code	M	SD
V1	4.24	0.43
V2	4.77	0.42
V3	4.57	0.49
V4	4.90	0.30
V5	4.28	0.45
V6	2.63	0.89
V7	1.65	0.93
V8	2.32	1.45
V9	3.99	0.82
V10	2.32	1.45
V11	1.13	0.38
V12	1.38	0.49
V13	4.17	0.37
V14	4.53	0.50
V15	4.07	0.26
V16	2.13	0.42
V17	4.04	0.20
V18	4.83	0.38
V19	4.12	0.33
V20	4.74	0.44

According to the above table, the results indicate that the majority of irrational beliefs (12 out of 20 items: e.g., V1, V2, V3, V4, V5, V13–V20) fall in the high range (M = 4.0–4.9), showing that most parents strongly endorsed irrational beliefs. Only a few items (V6, V8, V10, V16) were rated moderately, while very weak beliefs were found in V7, V11, and V12. This suggests irrational thinking patterns are widespread and often rigid among parents, particularly related to expectations about schools, government, and rapid rehabilitation.

Table 2: Comparison of Irrational Beliefs of Parents of Mild vs. Moderate ID Children

Variable	Mild (N=50) M (SD)	Moderate (N=100) M (SD)	p-value
V2	4.90 (0.30)	4.70 (0.46)	.002**
V3	4.94 (0.24)	4.39 (0.49)	.000**
V5	4.44 (0.50)	4.20 (0.40)	.004**
V6	3.26 (0.92)	2.32 (0.70)	.000**
V8	1.28 (0.45)	2.84 (1.50)	.000**
V10	1.28 (0.45)	2.81 (1.50)	.000**
V11	1.26 (0.49)	1.07 (0.29)	.013*
V18	4.92 (0.27)	4.78 (0.42)	.015*
V19	4.22 (0.42)	4.07 (0.26)	.023*

*Note: *p < .05; **p < .01*

The t-test revealed significant differences on 9 out of 20 variables, particularly in beliefs related to hopelessness about the future (V6), attributing full responsibility to teachers (V8), and expectation of immediate rehabilitation (V10). Parents of children with moderate ID scored higher on irrational beliefs in most cases, indicating that the severity of disability can intensify irrational parental thinking.

Table 3: Themes from Open-Ended Responses on Rehabilitation (N = 150)

Theme	Frequency (%)	Description
Externalizing responsibility	66%	Parents attributed rehabilitation solely to schools/government institutions.
Denial and overprotection	58%	Parents denied the child's limitations or engaged in overprotection, limiting independence.
Hostility toward teachers	42%	Parents expressed frustration and negative attitudes towards teachers.
Unrealistic expectations	61%	Parents expected rapid improvement or normalization, irrespective of severity.

The qualitative analysis highlighted that irrational beliefs have a direct negative impact on rehabilitation outcomes. By externalizing responsibility, denying limitations, or maintaining unrealistic expectations, parents limit their own participation in the rehabilitation process and create barriers to collaboration with teachers. Such beliefs reinforce dependency in children and reduce the effectiveness of adaptive skills training.

Discussion

This study examined parental irrational beliefs among parents of children with mild and moderate intellectual disabilities and their implications for rehabilitation engagement. Findings revealed highly endorsed irrational beliefs across the sample, notable differences between parent groups, and qualitative patterns illustrating how these beliefs impede adaptive rehabilitation processes.

The descriptive analysis indicated that a majority of variables (12 out of 20) had mean scores in the upper range (4.0–4.9), reflecting widespread and intense irrational cognitions. These pervasive beliefs likely stem from entrenched expectations—parental demands for schools, government institutions, or caregivers to bear complete responsibility (e.g., V1, V2, V3, V4, V5, V13–V20). According to Rational Emotive Behavior Therapy (REBT), irrational beliefs are often inflexible, absolutist thoughts such as "musts," "shoulds," or "oughts" that lead to emotional disturbance and maladaptive behavior as per the REBT model.

Such firm expectations serve to worsen parental disappointment when things go wrong with what they have wanted, and this supports negative emotions and behavioral detachment. The strength of such beliefs is associated with the fact that the research has indicated that cognition appraisals are significant correlates of both parental stress and coping (Hassall et al., 2005). Also cognition has been focused on through development of higher order or critical thinking skills (Jamil et al., 2023; Jamil et al., 2024; Jamil et al., 2025; Naseer et al., 2022).

Independent t-test demonstrated statistically significant results on nine variables against their intellectual disability level-particularly V2, V3, V5, V6, V8, V10, V11, V18 and V19-which revealed the irrational beliefs of parents of children with moderate intellectual disabilities in more areas than that of parents of children with mild ID. Especially notable are beliefs in futility over the future (V6), dependence on an educator (V8), and hopes that a rehabilitation will come quickly (V10) which are particularly high in the moderate group.

This tendency is in line with works that emphasize that increased child severity is associated with increased parental stress and dysfunctional appraisals (e.g., low efficacy or an external locus of control) (Hassall et al., 2005). In instances of moderate disability parents feel more burdens and lesser support provision, hence resulting in aggravated expectations that will require other parties to take up the responsibility. This attributional externality seems to echo through cultural discourses of disability as institutional as well as disaster. As a result, can get over-emotional, causing them to disassociate with active rehabilitation processes and reinforce the dependency cycles. Qualitative themes as externalizing responsibility (66%), denial and overprotection (58%), unrealistic expectation (61%), hostility towards teachers (42%) further highlighted how irrational beliefs determine the dynamics of rehabilitation. Such cognitive biases contribute to poor parent-teacher partnerships, and they hinder the development of the children since the father and mother become indirectly involved.

Qualitative themes as externalizing responsibility (66%), denial and overprotection (58%), unrealistic expectation (61%), hostility towards teachers (42%) further highlighted how irrational beliefs determine the dynamics of rehabilitation. Such cognitive biases contribute to poor parent-teacher partnerships, and they hinder the development of the children since the father and mother become indirectly involved.

Another example is considering that parents view rehabilitation as the responsibility of the school, they reduce efforts to intervene by reducing home-based support, consistency of training and adaptive skill maintenance. Rejection of any limitations and excessive protection may thwart experiments with autonomy in children and reinforce a maladaptive dependence strategy. The results resemble the general literature on parenting interventions- when parents form dysfunctional beliefs, the cooperation with professionals and the implementation of educational plans may get impaired, limiting therapeutic efficacy (Ranta et al., 2025).

Conclusion

This study reveals that irrational beliefs, particularly high-intensity "musts," externalized responsibility, and unrealistic expectations—are prevalent among parents of children with intellectual disabilities. These beliefs are more pronounced in the context of moderate disability and exert a dampening effect on parental engagement, rehabilitation collaboration, and ultimately, child adaptive outcomes. Cognitive-behavioral interventions, especially REBT-informed strategies, offer a promising path to transform belief systems, enhance coping, and improve rehabilitation effectiveness. Future research should rigorously test such interventions, broaden cultural, and gender perspectives.

Recommendations

1. Sessions should help parents identify absolutist "shoulds" and "musts," dispute them, and formulate rational self-statements. This approach targets high-intensity beliefs (e.g., V4: "special schools/teachers are solely responsible").
2. Focused on setting realistic rehabilitation expectations, communicating the roles of parents versus institutions, and reinforcing the value of parental involvement.
3. Educators and clinicians should foster collaborative partnerships, reinforcing that parents are central in rehabilitation, not peripheral stakeholders. Addressing hostility and denial may require mediated dialogues exploring belief origins and reframing.
4. Given more intense irrational beliefs among parents of children with moderate ID, interventions must explicitly address hopelessness and expectations of rapid progress.

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